SUBCHAPTER A. General Rules for Medical Billing and Processing
28 TAC §§133.2, 133.4, and 133.5

1. INTRODUCTION. The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §133.2 concerning definitions. The Commissioner also adopts new §133.4, concerning notification to healthcare providers of contractual agreements between insurance carriers and informal networks and/or voluntary networks, and new §133.5, concerning informal network and voluntary network reporting requirements to the Division. The amended and new sections are adopted with changes to the proposed text as published in the March 7, 2008, issue of the *Texas Register* (33 *TexReg* 1992).

2. **REASONED JUSTIFICATION**. The amendments to §133.2 are necessary to update existing rule definitions, and citations, and to add definitions recently enacted by Labor Code §413.0115. Adopted §133.4 is necessary to comply with Labor Code §413.011(d-2), effective September 1, 2007, which was enacted by House Bill (HB) 473, 80th Legislature, Regular Session. Pursuant to Labor Code §413.011(d-1), an insurance carrier or the insurance carrier's authorized agent may use an informal or voluntary network, as those terms are defined by Labor Code §413.0115, to obtain a contractual fee agreement that provides fees that are different from the Division's fee guidelines. In order to provide increased transparency of insurance carrier contractual fee arrangements with informal and voluntary networks, Labor Code §413.011(d-2) requires

the Commissioner by rule to establish the time and manner by which an informal or voluntary network, or the insurance carrier or the insurance carrier's authorized agent, must provide notice to each affected health care provider. The notice must inform the health care provider of any person that is given access to the health care provider's contractual fee arrangement with the informal or voluntary network. Labor Code §413.011(d-2) does not limit the duty of providing the notice to one entity but requires the informal or voluntary networks or insurance carrier, or insurance carrier agent, to give notice to health care providers of any access to their contractual agreements. To remain consistent with the statutory provisions of Labor Code §413.011(d-2), new §133.4 specifies the time and manner of providing notice to the health care provider and allows the insurance carrier, the insurance carrier's authorized representative, or the informal or voluntary network the flexibility to determine which entity will provide the requisite notice to affected health care providers. This flexibility in adopted §133.4 allows the insurance carrier, the insurance carrier's authorized agent, or the informal or voluntary network to deliver and document the notice using whatever method best fits its business needs, so long as the notice contains the requisite information, is delivered in accordance with the stated timeframes, and can be reproduced at the request of the Division. Notice by certified mail is not prohibited by adopted §133.4. However, due to the potential volume of notices that may become necessary pursuant to Labor Code §413.011(d-2) and the Division's recognition of substantial costs associated with

providing notice by certified mail to affected health care providers, adopted §133.4 does not restrict notice to this one method of delivery.

Adopted §133.5 is necessary to specify additional reporting requirements by informal networks and voluntary networks to the Division and to include the reporting requirements established by Labor Code §413.0115.

The Division posted an informal draft of the amendments to §133.2, new §133.4, and new §133.5 on the Department's website on November 6, 2007. The Division published the proposed text of the amended and new sections in the March 7, 2008, issue of the *Texas Register.*

In response to written comments received from interested parties and for the purpose of clarity, the Division has changed some of the proposed language in the text of the rule as adopted. The changes, however, do not introduce new subject matter or affect persons in addition to those subject to the proposal as published.

Section 133.2. In paragraphs (1) and (6), the Division has added the terms "the Insurance Code" and "Department," deleted the term "or" before "Division" and added the term "or" after Division. These changes from proposal are necessary because an insurance carrier's responsibilities for claims services functions, including medical bill processing, are broad in the workers' compensation system, and include, compliance by an insurance carrier, and its agents, with all applicable provisions in the Insurance Code, the Labor Code, Division, and/or Department rules.

Section 133.4. Adopted subsection (a), regarding applicability was added as a result of public comments requesting clarification that this section applies to contracted fees that are negotiated by an informal or voluntary network and is not applicable to payments made under a certified health care network agreement pursuant to Insurance Code Chapter 1305. Due to the addition of an applicability provision in subsection (a), the subsequent subsections were renumbered. In subsection (b), the additional language of "insurance carrier" is a change from proposal as a result of public comments to clarify that an insurance carrier could satisfy the definition of "person" in this subsection for compliance with the notice requirements. Specifically, if an informal or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed to an insurance carrier, the insurance carrier would satisfy the definition of "person" in subsection (b). For the purpose of clarity, the Division changed from proposal the subsection (c) subheading from "Required Notification" to "Required Notice." In adopted subsection (c), the deletion of ", including, but not limited to, any person to whom the informal or voluntary network's fee arrangement with that health care provider is sold, leased, transferred, or conveyed," is also a change from proposal in response to public comments to delete the varying language for the meaning of "person" in proposed subsection (b). Some commenters recommended referring to the definition of "person" in an effort to avoid confusion and perceived inconsistencies about the meaning of the term "person" as it relates to when notice is required.

For the purpose of clarity, the Division changed from proposal the subsection (d) subheading from "Content of notification" to "Notice." Also for clarification, the Division deleted "Notification" and "shall include" and replaced those terms so that the initial phrase for subsection (d) states "Notice to each contracted health care provider." Adopted (d)(1) has changed from proposal for the purpose of clarity and to specify the type of contact information required in the notice to each contracted health care provider for the informal or voluntary network. Adopted (d)(1) adds "must include the" and ", but not limited to, the name, physical address." These changes clarify that the contact information in the notice must also include the name of the informal or voluntary network and the physical address. With the additional language of "but not limited to" the sender of the notice may additionally include such contact information as the informal or voluntary network's fax number or email address. However, this change from proposal specifies that, at a minimum, the notice must include the name of the informal or voluntary network, the physical address, and a toll-free telephone number.

For the purpose of clarity and in response to public comments, subsection (d)(2) includes changes from proposal. Specifically, the Division added "must include" in subsection (d)(2). In subsection (d)(2)(A), the Division found it necessary to make changes from proposal to clarify the type of contact information that is required when the sender of the notice informs the health care provider that a person is given access to the informal or voluntary network's fee arrangement with a health care provider. Specifically, subsection (d)(2)(A) adds "name, physical address, and telephone number"

and deletes "contact information." In addition, in response to public comments, the Division deleted "and identification," "insurance carrier, or other" and "including, but not limited to, any person to whom the informal or voluntary network's fee arrangement with the health care provider is sold, leased, transferred, or conveyed." Since subsection (b) defines "person" and clarifies that an insurance carrier would satisfy the definition of "person" if an informal or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed to an insurance carrier, the changes from proposal in adopted subsection (d)(2)(A) are necessary to avoid possible inconsistencies and confusion about the meaning of "person" as it relates to notice. The Division renumbered this subsection from §133.4(d) to §133.4(d)(3) for the purpose of clarity. Adopted subsection (d)(3) has further changed for clarification which include deleting "Method of Notification" as the subsection heading and deleting the phrase "[t]he information listed in subsection (c) of this section." An additional change in adopted subsection (d)(3) includes deleting the phrase "[A] link to a website may be provided only if the website:" to place a portion of that phrase in renumbered subsection (d)(4). Clarification changes were made in adopted subsection (d)(4), the phrase "to a website may be provided" was deleted and the phrase "may be provided through a website link only if the website:" was added. Adopted subsection (d)(4)(A) and (B) are re-numbered subsections from proposal. Adopted subsection (d)(4)(A) is structurally revised to add "(d)(1)" and the renumbered "(d)(2)(A)"and "(d)(2)(B)." Adopted subsection (d)(4)(B) has changed since proposal due to public comments requesting

that the Division delete the word "and," add the phrase "with current and correct information," and delete proposed subsection (d)(3). Commenters expressed concern that, although proposed subsection (d)(2) recognized the need to periodically update the website information available to health care providers, proposed subsection (d)(3) suggested that the information on the website must always be current and correct. The Division clarifies with the change to subsection (d)(4)(B) that, at the very least, a monthly update of the sender's webpage with current and correct information is expected. Accordingly, the Division deleted proposed (d)(3) which stated "contains current and correct information."

Adopted subsection (e) has changed since proposal to add "information provided," and "as required by subsection (d)," as well as deleting the phrase "content of the notice" due to the change in subsection (d) from "Content of Notification" to "Notice." Further changes since proposal in adopted subsection (e) were made in response to a written comment. The words "method of" were added and the words "of the notice" were deleted. Further, the sentence "[f]or the purpose of this section, a notice is determined to be delivered in accordance with §102.4(p)" was added. In response to a written comment that it is often difficult to pinpoint the actual delivery date, these changes from proposal are necessary in order for the sender to document the manner in which the notice was provided to affected health care providers and the date of delivery. To determine the date that a notice is delivered to an affected health care

provider, this change makes clear that the sender should refer to the existing Division rule §102.4(p) for the purpose of determining the date of receipt.

Changes from proposal were made in adopted subsections (f)(1) and (f)(2) due to the later than anticipated date of this section's adoption. The Division has deleted the terms "June" and "September" and replaced them with "August" and "November" in adopted subsection (f)(1). As explained in the proposal for subsection (f)(1), a period of ninety days should provide the informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent with sufficient time to determine which entity will provide the initial notice for contracts in effect on August 1, 2008. Accordingly, the Division has deleted the word "June" and replaced it with the term "August" in subsection (f)(2).

In response to written comments suggesting that the proposed subsection could mistakenly be interpreted to apply to payments made under a certified healthcare network, the Division added to subsection (g), the phrase "negotiated by an informal network or voluntary network." For the purpose of clarity and to remain consistent with Labor Code §413.011 and subsection (c), which require the sender of the notice to do so within the time and manner provided by this section, the Division deleted proposed subsection (g)(1), which stated "the notice to the health care provider does not meet the criteria outlined in subsections (c)(2)(A) and (c)(2)(B) of this section; or" and the terms "subsections (b)-(f)." Due to the changes, the Division re-numbered subsection (g). In response to written comments requesting that the Division provide guidance on

reimbursement in the absence of an applicable Division fee guideline, adopted subsection (h) has been changed since proposal to add "pursuant to §134.1(e)(1), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable pursuant to §134.1(e)(3)."

Changes since proposal were made to adopted subsection (i) for the purpose of clarity. The Division deleted the term "notification" and replaced it with the term "notice." Additionally, for the purpose of clarity and to remain consistent with Labor Code §413.011 and adopted subsection (c), which require the sender of the notice to send notice within the time and manner provided by this section, the Division deleted the phrase "of subsections (b)-(e)."

Another change made since proposal is in subsection (j) to clarify and add the subheading title "Severability Clause."

Similarly, a change since proposal was made to adopted subsection (k) for the purpose of clarity and consistency throughout the section. This change was the addition of the subheading title "Expiration." In response to written comments suggesting that proposed subsection (k) may create confusion in 2011 as to whether or not there is any rule in place to assist in deciding unresolved fee disputes over services rendered prior to January 1, 2011, the Division added "[t]his section will continue to apply to health care services rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider."

Section 133.5. Due to the later than anticipated adoption of this section, the Division made a change to adopted subsection (c) since proposal. Specifically, the Division deleted the term "June" and replaced it with "August." For the purpose of clarity, the Division made a change to adopted subsection (e) by adding "informal and voluntary network" and deleting "to the Division."

3. HOW THE SECTIONS WILL FUNCTION.

Amendments to §133.2, concerning definitions are adopted for Subchapter A, General Rules for Medical Billing and Processing. New §133.4(a) states that the section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider in accordance with Labor Code §413.011 and §413.0115. Subsection (b) defines the term "person" under the section and specifies that the term "person" does not include an injured employee. Subsection (c) specifies the required notice by an informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, to each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider within the time and manner provided by this section. Subsection (d) establishes the information required in the notice to each contracted health care provider. Specifically, subsection (d)(1) states that notice to each contracted health care provider must include the contact information for the informal or voluntary network, including, but not limited to, the name, address,

and a toll-free telephone number accessible to all contracted health care providers. In addition, subsections (d)(2)(A) and (d)(2)(B) further require that notice to each contracted health care provider must include specific information in the body of the notice. Such information includes the name, address, and telephone number of any person that is given access to the informal or voluntary network's fee arrangement with a health care provider, and the start date and any end date during which any person has been given access to the health care provider's fee arrangement. Subsection (d)(3) provides that notice to each contracted health care provider may be provided in an electronic format provided a paper version is available upon request by the Division. In addition, subsections (d)(4)(A) and (d)(4)(B) provide that notice to each contracted health care provider may be provided through a website link only if the website link contains the information stated in subsections (d)(1), (d)(2)(A), and (d)(2)(B) of this section and is updated at least monthly with current and correct information. Subsection (e) provides that the informal or voluntary network, insurance carrier or the insurance carrier's authorized agent, as appropriate, shall document the information provided in the notice as required by subsection (d), the method of delivery, to whom the notice was delivered, and the date of the delivery. Subsection (e) further provides that for purposes of this section, a notice is determined to be delivered in accordance with §102.4(p). Additionally, subsection (e) states that failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable

presumption in a Division enforcement action or in a medical fee dispute that the health care provider did not receive the notice. Subsection (f) provides for the time of notification. Subsection (f)(1) states that for contracts with health care providers in effect on August 1, 2008, initial notification must be made no later than November 1, 2008, and subsequent notices to health care providers in accordance with this section shall occur thereafter on a quarterly basis. Subsection (f)(2) provides that for contracts with health care providers entered into after August 1, 2008, initial notification must be made no later than the 30th day after the effective date of the contract and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis.

Subsection (g) provides that the insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115. Subsection (h) provides that if the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3).

Subsection (i) provides that if notice to the health care provider does not meet the requirements of this section, the insurance carrier may be held liable for administrative violations in accordance with Labor Code provisions and Division rules. Subsection (j) contains a severability clause stating that if a court of competent jurisdiction holds that any provision of the section is inconsistent with any statutes of this state, is unconstitutional, or is found to be invalid for any reason, the remaining provisions of this section shall remain in effect. Subsection (k) provides that in accordance with Labor Code §413.011(d-6), the provisions of the rule shall expire on January 1, 2011. Subsection (k) further provides that the section will continue to apply to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider.

New §133.5(a) provides for the reporting requirements and states that each informal network and voluntary network must provide the following information to the Division: (1) the informal network or voluntary network's name and federal employer identification number (FEIN); (2) an executive contact for official correspondence for the informal or voluntary network; (3) a toll-free telephone number by which a health care provider may contact the informal network or voluntary network; (4) a list of each insurance carrier with whom the informal network or voluntary network contracts, including the insurance carrier's FEIN; and, (5) a list of each entity or insurance carrier

agent associated with the informal or voluntary network working on behalf of the insurance carrier, including contact information for each entity.

Subsection (b) provides for the reporting format and states that reports, including changes, must be submitted through the Division's on-line reporting system accessible through the Division's website at www.tdi.state.tx.us. Subsection (c) provides that each informal network and voluntary network that has a contract with an insurance carrier or an insurance carrier's authorized agent in effect on September 1, 2007, must report to the Division in accordance with this section no later than August 1, 2008. Subsection (c) further provides that except as provided in the subsection, informal and voluntary networks must report to the Division no later than the 30th day after the effective date of a contract signed with an insurance carrier or an insurance carrier's authorized agent.

Subsection 133.5(d) provides that each informal network and voluntary network shall report any changes to the information provided under subsection (a) of the section to the Division not later than the 30th day after the effective date of the change in accordance with Labor Code §413.0115 and the section. Subsection 133.5(e) provides that if the informal and voluntary report does not meet the requirements of Labor Code §413.0115 and this section, the informal network or voluntary network may be held liable for any administrative violations. Subsection (f) provides that the provisions of this rule shall expire on January 1, 2011.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

Section 133.2(6): A commenter states that the proposed definition of "insurance carrier agent" seems to include medical bill processing within the category of claims services. The commenter recommends revising the language to more clearly distinguish the two since medical bill processing and claims services are mutually exclusive functions.

Agency Response: The Division does not agree that a revision of §133.2(6) for the purpose of distinguishing medical bill processing functions from claims services function is necessary. Medical bill processing is a claims services function. Any person or entity with whom the workers' compensation insurance carrier contracts or utilizes on its behalf to provide any claims services function, including medical bill processing, pursuant to the Labor Code, Insurance Code, Division or Department rules is considered an insurance carrier agent. Because an insurance carrier's responsibilities for claims services functions, including medical bill processing, are broad in the workers' compensation system, the Division has added language to the definitions of "bill review" in §133.2(1) and "insurance carrier agent" in §133.2(6) to clarify that an insurance carrier and its agents must comply with all applicable provisions in the Labor Code, the Insurance Code, Division or Department rules.

Section 133.4: A commenter recommends that the rules for informal networks and voluntary networks, and any associated rules provide as much flexibility as possible to allow contracts between insurance carriers and informal networks or voluntary networks to specify which entity will assume the responsibilities for the mandates set out in

statutory requirements that govern the use of informal and voluntary network agreements with insurance carriers and health care providers. The commenter recommends that the proposed rules do not micromanage any portion of the new insurance carrier contract provisions with informal or voluntary networks and informal or voluntary network contract provisions with health care provider contracting provisions as amended by HB 473.

Agency Response: The Division agrees that if a carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual agreement that provides for fees different from the Division's fee guidelines, Labor Code §413.011(d-2) would require an informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, to notify each health care provider of any person that is given access to the fee arrangement within the time and manner of this new section. New §133.4(c) allows the insurance carrier, the insurance carrier's authorized agent, or the informal or voluntary network, the flexibility to determine which entity will provide the notice to affected health care providers, as well as the flexibility to deliver and document the notice using whatever method best fits its business needs so long as the notice contains the requisite information, is delivered in accordance with the stated timeframes, and can be reproduced at the request of the Division.

Section 133.4: A commenter describes its organization as a nonprofit entity governed by a professional medical association with a medical board of directors. This entity

does not require its providers to send their bills to them. The commenter explains that several insurance companies have contracted with it to obtain the credentialing information to become certified. The commenter explains that it does not provide the credentialing for them but only tries to negotiate on the provider's behalf to obtain the best possible rates from the carriers. The commenter further states that it submits to the insurance carriers all of the credentialing applications for every provider that agrees to accept the rates offered to its group. Each provider bills and gets paid by the insurance carrier and the commenter does not get involved or charge a percentage from the carriers or providers. Commenter questions whether it is an informal or voluntary network based on the information it has provided.

Agency Response: The commenter appears to be requesting that the Division confirm whether the commenter's operations constitute an informal or voluntary network. The Texas Department of Insurance, Division of Workers' Compensation, as a regulatory agency, is not authorized to render legal opinions or advice regarding a specific factual scenario. However, the Division points out that Labor Code §413.0115 and Division rule §134.2 define an "informal network" as "a health care provider network described by Labor Code §413.011(d-1) that: (A) is established under a contract between an insurance carrier and health care providers; and (B) includes a specific fee schedule. In addition, a "voluntary network" is defined as "a voluntary workers' compensation health care delivery network established by an insurance carrier under

former Labor Code §408.0223, as that section existed before repeal by Chapter 265, Acts of the 79th Legislature."

Section 133.4: A commenter states that the informal networks and voluntary networks have operated with essentially no regulation. Because of the business practices used by some of the informal and voluntary networks, health care providers have had difficulty obtaining information needed to determine whether the reimbursement received was appropriate for the treatment provided to injured employees. The commenter states that HB 473 was adopted to address this concern.

Agency Response: The Division appreciates the comment and agrees that HB 473, codified at Labor Code §413.011 (d-1), clarifies the law authorizing deviations from the medical fee guidelines. Labor Code §413.011(d-1) and (d-2) require certain contractual arrangements and notification requirements to health care providers should an insurance carrier or the carrier's authorized agent seek to use an informal or voluntary network to obtain a contractual agreement that provides for fees different from the fees authorized under the Division's fee guidelines.

Section 133.4: A commenter states that the Division should specifically clarify that these provisions do not apply to pharmacy benefit management programs. The commenter explains that pharmaceutical services are specifically excluded from networks certified under Chapter 1305 of the Insurance Code. The commenter further

states that since voluntary networks and informal networks are required to be certified in accordance with Chapter 1305 by 2011, it serves to reason that these rules should not apply to pharmaceutical providers.

Agency Response: The Division clarifies that this section applies to any contractual agreement between an insurance carrier, or the insurance carrier's authorized agent, and an informal or voluntary network, and a health care provider, that provides for fees different from the fees authorized under the Division's fee guidelines pursuant to Labor Code §413.011(d-1). The Division agrees that pursuant to Labor Code §413.0115(b), not later January 1, 2011, each informal network or voluntary network must be certified as a workers' compensation health care network under Chapter 1305, Insurance Code. The Division further agrees that prescription medication or services, as defined by Labor Code §401.011(19)(E), may not be delivered through a workers' compensation health care network under Insurance Code §1305.101(c), but, are instead, reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the Commissioner of workers' compensation in accordance with Insurance Code §1305.101(c). Whether or not a pharmacy benefit management program can be licensed as a certified network in the future is not contingent on HB 473 (80th Legislature); rather, the issue is whether or not the pharmacy benefit management program meets the certification requirements under Chapter 10 rules and TIC Chapter 1305 on January 1, 2011. However, the Division points out that a prescription medication is defined as "health care" under Labor Code §401.011(19) and that

pharmacists and pharmacies are considered health care providers under Labor Code §401.011(21) and (22). Additionally, if an entity is performing the acts of an informal or voluntary network as defined by Labor Code §413.0115 and Division rule §133.2, then that entity is subject to regulation under the provisions of HB 473 and applicable Division rules.

Section 133.4: A commenter recommends language be added to provide that after receipt of the notice required under subsection (b), a physician or health care provider may object to the addition of an insurance carrier or person's access to a discounted fee, that the health care provider may terminate its contract by providing written notice to the voluntary network not later than the 30th day after receiving the notice, and that an insurance carrier may not access or be entitled to the contracted rate following the physician's objection. The commenter also recommends the notice include the address to which a physician may send his or her objection. The commenter recommends that an informal or voluntary network may not terminate the physician-network contract, modify the contracted rate, or otherwise retaliate against a physician for objecting to the addition of an insurance carrier as a payor under his or her contract.

Agency Response: The Division disagrees. The recommended language is beyond the rulemaking authority of the Division. Labor Code §413.011(d-2) requires the Division to establish the time and manner that an informal network or voluntary network, or the carrier, or the carrier's authorized agent, as appropriate, must notify the health

care provider of any person that is given access to the network's fee arrangements with that health care provider. Health care providers are encouraged to review the termination clause provisions in the contracts they sign with informal and voluntary networks to determine the notice provisions, if any, that are required before a health care provider terminates his contract with the informal or voluntary network.

Sections 133.4(b) and (c): A commenter requests that the definition of "person" in proposed §133.4(a) and the notification requirement in proposed §133.4(b) retain a specific reference to situations in which the fee arrangement is leased. The commenter further recommends that proposed §133.4 clearly encapsulates existing situations in which an informal network or voluntary network leases its network to another entity, which then leases it to yet another third entity.

Agency Response: The Division agrees that the definition of "person" in adopted §133.4(b) applies to any time that an informal or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed to another individual or entity on behalf of an insurance carrier. The term "person," however, does not include an injured employee. For this reason, the Division does not agree that further changes to the definition of "person" in new §133.4(b) are necessary, or that changes to the required notice provision in new §133.4(c) are necessary for the purpose of addressing the multiple selling, leasing, transferring, or conveying of such fee

agreement. New §133.4(b) and new §133.4(c) specify when a notice to the contracted health care provider is required.

Sections 133.4(b)-(c) and (d)(2)(A): A commenter recommends including insurance carriers in the definition of "person" in proposed §133.4(a). The commenter states that it appears the Division intends for carriers to comply with the requirements for a "person" in the rule since proposed §133.4(c)(2)(A) refers to an "…insurance carrier, or other person…" and proposed §133.4(b) refers to "…any person to whom the informal or voluntary network's fee arrangement with that health care provider is sold…" The commenter recommends including the term "carriers" in the definition of person in proposed §133.4(a) and removing other subsection references to "insurance carriers or other persons" since such phrase is not used consistently.

Another commenter states that proposed §133.4(a) defines "person" as "an individual, partnership, corporation or other entity to whom an informal network or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier," excluding an injured worker. The commenter believes this definition limits the term "persons" to customers of the voluntary or informal network whose identities are of significance to providers. The commenter states that proposed §133.4(b) directs that the health care provider receive notice of "any person that is given access to the network, including, but not limited to, any person to whom the fee arrangement is sold, leased, transferred or conveyed." The

commenter states that since "person" is defined in proposed §133.4(a) to include an entity to whom a voluntary or informal network's fee arrangement is sold, leased, transferred or conveyed, the varying language in proposed §133.4(b) is likely to lead to confusion. The commenter recommends using the defined term "person" in proposed §133.4(b), so that the language would read: "Each informal or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement." The commenter recommends a similar change with respect to proposed §133.4(c)(2)(A) for the same reasons.

Agency Response: The Division agrees that "person" applies to any individual or entity, including, but not limited to, an insurance carrier, to whom an informal or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier. In the event that such fee arrangement is sold, leased, transferred, or conveyed to an insurance carrier, the insurance carrier would satisfy the definition of "person" in adopted §133.4(b). For purposes of clarifying this intent, the Division specifically adds the term "insurance carrier" to the definition of "person" in new §133.4(b). The Division further agrees that since new §133.4(b) defines "person," it is necessary to delete in adopted §133.4(c) the phrase "including, but not limited to, any person to whom the informal or voluntary network's fee arrangement with that health care provider is sold, leased, transferred, or conveyed" in an effort to avoid confusion about the meaning of "person" as it relates to

when notification is required. For the same reason, it is necessary to delete in adopted §133.4(d)(2)(A), the phrases "insurance carrier, or other" and "including, but not limited to, any person to whom the informal or voluntary network's fee arrangement with the health care provider is sold, leased, transferred, or conveyed." These changes avoid possible inconsistencies in the meaning of "person."

Section 133.4(c): A commenter states that proposed §133.4 does not specify whether the informal or voluntary network, or the insurance carrier, has the duty to notify the affected health care provider. The commenter also suggests that both informal/voluntary networks and insurance carriers have a duty to notify a physician of the intent to alienate or access a contract rate arrangement. The commenter recommends the rule require the informal or voluntary networks to provide the notification but allow an informal or voluntary network to delegate the function of notification, yet retain the ultimate responsibility for all delegated functions and be directly accountable for compliance. A commenter recommends the rule require the insurance carrier or insurance carrier's agent to provide the notification but allow the carrier or the insurance carrier's agent to delegate the function of notification, yet retain the ultimate responsibility for all delegated functions and be directly accountable for compliance. For both recommendations, the delegation must be evidenced in writing; retained by the informal or voluntary network for a period of 6 years from the anniversary of the termination of the delegation agreement; and made available on

request of the Division. A commenter recommends an insurance carrier or the insurance carrier's agent, as soon as practicable, should be required to notify each physician upon obtaining the right or authorization to access a contracted rate of the physician.

Agency Response: The Division disagrees. Labor Code §413.011(d-2) does not specify which entity has the responsibility to notify a health care provider of any person that is given access to the network's fee arrangements with that health care provider. If a carrier or the carrier's authorized agent chooses to use an informal or voluntary network, Labor Code §413.011(d-2) would require an informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, to notify each health care provider of any person that is given access to the fee arrangement. To remain consistent with the provisions of Labor Code §413.011(d-2), new §133.4 allows the insurance carrier, the insurance carrier's authorized agent, or the informal or voluntary network, the flexibility to determine which entity will provide the notice to affected health care providers. In addition, new §133.4(i) provides that the insurance carrier may be held liable for administrative violations in accordance with applicable Labor Code provisions and Division rules if there is non-compliance with the required notice. Additionally, the Division disagrees with the recommendation that the notice be provided to affected health care providers "as soon as practicable." Labor Code §413.011(d-2) requires the Division to adopt rules regarding the time and manner by which these

notices are sent to health care providers. As a result, the Division adopts new §133.4 to provide guidance regarding the time and manner for these notices.

Sections 133.4(c)-(f): A commenter states that proposed §133.4 creates reasonable parameters for the notification requirements. The commenter believes that the information required in the written notifications and the time frames for notification will improve the present situation for system participants. The commenter states that the time frames in proposed §133.4(f) are appropriately tailored and reasonable for informal and voluntary networks.

Agency Response: The Division agrees. Adopted §133.4 will provide increased transparency of a person's access to a health care provider's contractual fee arrangement with an informal or voluntary network as required by Labor Code §413.011(d-2).

Sections 133.4(c)-(f): A commenter recommends that the required notice must notify each affected health care provider via certified mail of any person that is given or sold access to the network's fee arrangement with that health care provider within the time and manner provided by the rule, that the notice must be sent certified mail every 45 days, and include a separate prominent section that lists the insurance carriers that the informal or voluntary network knows will have access the network's fee arrangement.

The commenter further recommends that the sender of the notice maintain documentation of the delivery and the date(s) of the certified mail delivery.

Agency Response: The Division disagrees that notice may only be provided by certified mail. Notice by certified mail is not prohibited by adopted §133.4. However, due to the potential volume of notices that may become necessary pursuant to new §133.4, an administrative rule that would restrict notice to certified mail would result in substantial costs to the entity providing notice to the affected health care providers. Instead, new §133.4 allows the insurance carrier, the insurance carrier's authorized agent, or the informal or voluntary network, the flexibility to deliver and document the notice using whatever method best fits its business needs so long as the notice contains the requisite information, is delivered in accordance with the stated timeframes, and can be reproduced at the request of the Division. Also, §133.4(d) provides that notice to each affected health care provider must include the contact information of any person that is given access to the informal or voluntary network's fee arrangement.

Regarding the recommendation to require that the sender of the notice maintain documentation of the delivery of the notice, the Division points out that new §133.4(e) provides guidance regarding health care provider notice documentation requirements. Specifically, §133.4(e) states that the "the informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall document the information provided in the notice as required by subsection (d), the method of delivery, to whom the notice was delivered, and the date of delivery. For the purpose of this

section, a notice is determined to be delivered in accordance with §102.4(p), relating to General Rules for Non-Commission Communication. Failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption in a Division enforcement action and in a medical fee dispute that the health care provider did not receive the notification."

Section 133.4(d): A commenter recommends rule language to require the notice include a separate prominent section that delineates any reimbursement policies, such as maximum frequency per day limitations, which may affect the contracted rate of the physician.

Agency Response. The Division disagrees with the recommendation to require reimbursement policies within the notice. Division points out that all health care provided in the Texas workers' compensation system is subject to the billing requirements under the Labor Code and Division rules. Additionally, non-network or out-of-network health care, whether paid as part of an informal or voluntary network contractual arrangement or not, is subject to the Division's treatment guidelines, preauthorization requirements and medical dispute resolution requirements as set out in the Labor Code and Division rules. Informal or voluntary networks are not authorized to vary from the billing or reimbursement requirements under the Labor code and Division

rules, with the exception of negotiating a fee amount with the health care provider that varies from the Division's fee guidelines for that same health care service.

Section 133.4(d)(4)(B): Some commenters state that the proposed rule recognizes that the list of health care providers and workers' compensation carriers covered by an informal or voluntary network is likely to change frequently as parties are added to or removed from contractual agreements. Proposed subsection (d)(2) recognizes the need to periodically update the information available to health care providers while proposed subsection (d)(3) unrealistically suggests that the information on the website must always be "current and correct…" In order to avoid the potential conflict in wording, some commenters recommend deleting proposed subsection (d)(3) and replacing proposed subsection (d)(2) with new language to read, "is updated at least monthly with current and correct information."

Another commenter states that the original proposal appears to require the webpage to be updated at least monthly, even if nothing changes. The commenter recommends deleting proposed §133.4(d)(2) and (3) and replacing those proposed subsections with the following language so that the information is current and correct, but would not require the information to be updated every single time there is a change: "(2) contains current and correct information, but is not required to be updated more frequently than monthly."

Agency Response: The Division clarifies that a person to whom an informal network or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier may provide notice to each contracted health care provider through a website link only if the website link contains the information required by adopted §133.4(d)(4). New §133.4(d)(4)(A) and (B) provide that notice to each contracted health care provider may be provided through a website link only if the website link contains the information stated in subsections (d)(1), (d)(2)(A) and (d)(2)(B) and is updated at least monthly with current and correct information. This change clarifies that, at the very least, a monthly update of the webpage with current and correct information is expected.

Sections 133.4(d) and (f): A commenter recommends that the required notice should include the contact information and identification of any insurance carrier, or other person, that has access to the contracted fee arrangement, as well as the contracted range of dates during which the insurance carrier, or other person, has been granted access to the contracted fee arrangement; posting of a list on a secure internet website that includes a separate prominent section that lists the payors that the voluntary network knows will have access to a discounted fee of the physician or health care provider in the succeeding 45-day period. Commenter further recommends that notice must be made within five business days of providing another insurance carrier or person access to the network's fee arrangement.

Agency Response: The Division disagrees that the recommended change in the rule language is necessary. Section 133.4(d) provides that notice to each affected health care provider must include the contact information of any person that is given access to the informal or voluntary network's fee arrangement with a health care provider and the dates during which the person may access a contracted rate. The definition of "person" in new §133.4(b) includes individuals, entities, and also insurance carriers. The term "person" does not apply to an injured employee.

In addition, adopted §133.4(f)(1) and (2) provide the time frames in which the notice must be provided to the affected healthcare providers. New §133.4(f)(1) states that for contracts with health care providers in effect on August 1, 2008, initial notification must be made no later than November 1, 2008, and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis. New §133.4(f)(2) states that for contracts with health care providers entered into after August 1, 2008, initial notification must be made no later than the 30th day after the effective date of the contract and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis. New §133.4(f) provides sufficient time for the health care provider to receive the initial and subsequent notices while providing the sender with sufficient time to deliver the notices. For this reason, health care providers can be assured that they are constantly receiving information about which insurance carriers have access to their contractual fee

arrangements and the senders of the notices can adequately administer the notice delivery process with multiple health care providers.

Entities that provide notice through a website link may do so pursuant to §133.4(d)(4) only if the website contains the information stated in subsections (d)(1), (d)(2)(A) and (d)(2)(B) of this section, and is updated at least monthly with current and correct information.

Section 133.4(e): A commenter states that the informal or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, should maintain and be prepared to present to the Division a record of compliance with the notice requirement. The commenter states it is often difficult to pinpoint the actual delivery date, depending on the method of notice, and, therefore, recommends changing each instance of the term "*delivered*" in proposed §133.4(e) to "dispatched," as the dispatch of the notice is broad enough to include all permissible methods of notice, and is within the control and knowledge of the informal or voluntary network, insurance carrier, or authorized agent.

The commenter further states that the proposed rule does not impose any obligation on the health care provider to ensure that the contact information he or she has provided to the informal or voluntary network, insurance carrier, or authorized agent is correct for purposes of receipt of the notice. The commenter explains that the absence of such a provision may both undermine the value of the rule's notice

mechanism and subject the informal or voluntary network, insurance carrier, or authorized agent to a penalty for deliveries that fail for reasons outside of its control. The commenter recommends a provision that would require the health care provider to keep the informal or voluntary network, insurance carrier, or authorized agent, as appropriate, apprised of its current contact information; or, alternatively, a provision that would relieve the informal or voluntary network, insurance carrier, or authorized agent from a penalty in the event the notice was dispatched but not received due to a health care provider's failure to provide current contact information.

Agency Response: The Division agrees that the method of delivery will assist in determining the date of receipt of the notice by the affected health care provider. The Division has added language to clarify that the sender of the notice is required to document the method of delivery and has deleted the "delivery of the notice" language in subsection (e). The Division further added language stating that "[f]or the purpose of this section, a notice is determined to be delivered in accordance with §102.4(p)." In response to a written comment that it is often difficult to pinpoint the actual delivery date, these changes from proposal are necessary in order for the sender to document the manner in which he provided notice to an affected health care provider and the date of delivery. To determine the date that a notice is delivered to an affected health care provider, the sender should refer to the existing Division rule §102.4(p) in order to establish the date of receipt, which, under the provisions of this section, is based on the method of delivering the notice.

The Division does not agree that it is necessary to require, through the rulemaking process, that the health care provider ensure that the contact information he or she has provided to the informal or voluntary network, insurance carrier, or authorized agent is correct for purposes of receipt of the notice. The Division expects informal and voluntary networks to address issues relating to maintaining accurate contact information for its contracted health care providers through the description of each party's duties in the contract itself. In addition, Labor Code §413.011(d-2) does not impose such rulemaking responsibility on the Commissioner. Instead, Labor Code §413.011(d-2) requires a Commissioner rule to implement the time and manner by which an informal or voluntary network, or the insurance carrier or the insurance carrier's authorized agent, as appropriate, shall notify each health care provider of any person that is given access to the informal or voluntary network's fee arrangements with that health care provider.

Sections 133.4(e)-(f): A commenter states that even though the Division has taken the cost of electronic and paper notifications to health care providers into consideration, it has not considered the cost of manpower and hours it takes to print letters, labels, envelopes, and then stuff them all to mail. The commenter states that it will be time consuming for the personnel required to notify the health care providers and time consuming for the mail room personnel responsible for stamping. The commenter states that copies of the notification have to be filed into the provider files which will also

be time consuming. The commenter questions the necessity of placing a copy of the notification in an entity's file for the provider if the entity has documentation that it sent the required notification. The commenter states that it is too costly and time consuming to notify health care providers on a quarterly basis if nothing has changed since the first notification. The commenter recommends sending subsequent notifications only when there is a change that makes it necessary to inform the health care provider(s).

Agency Response: The Division points out that the requirement for the insurance carrier, carrier's authorized agent or informal or voluntary network to provide a notice to health care providers is a statutory requirement enacted by HB 473 during the 80th Legislature. In an effort to reduce costs for those entities charged with providing the required notice, the Division has given the insurance carrier, the insurance carrier's authorized agent, and the informal and voluntary network, the flexibility to determine which entity will provide the notice to affected health care providers, as well as the flexibility to deliver and document the health care provider notice using whatever method best fits its business needs, so long as the notice contains the required information, is delivered in accordance with the timeframes stated in adopted §133.4(f), and can be reproduced at the request of the Division. Administrative costs are varied and dependent on the notifying entity's business model, its use of technology and automation, and employee pay-scale. Each notifying entity's business model will determine the costs for that entity's business procedures since the use of automation and manual labor will vary for each entity. Additionally, new §133.4 does not dictate

the method that an informal or voluntary network should use to maintain documentation that notice was delivered. Rather, new §133.4 simply specifies what information needs to be documented and available at the request of the Division. Finally, the commenter states that quarterly notices are too costly and time consuming and that notice should only be provided when there is a change that needs to be communicated to health care providers. The Division appreciates the comment, but disagrees that a quarterly notice is too costly or time consuming given that the sender has flexibility to choose the method of delivery. The Division considered requiring a quarterly notice only when changes occur, but determined that requiring a quarterly notice to all contracted providers would be easier for the sender to administer for compliance purposes than requiring a sender to send out individual notices to health care providers at certain time periods when individual changes occur. For these reasons, the Division disagrees that a change to adopted §133.4(f) pertaining to the time of notification is necessary.

Section 133.4(f)(1): A commenter questions whether the Division foresees a change to the deadline date of September 1, 2008, for notifying affected health care providers with voluntary or informal network contracts in effect on June 1, 2008, of the payors that can access their fee schedules.

Agency Response: The Division clarifies that changes from proposal were made in subsection (f)(1) due to the later than anticipated date of the section's adoption. The Division has deleted the terms "June" and "September" and replaced them with "August"

and "November" in subsection (f)(1). As explained in the proposal for subsection (f)(1), a period of ninety days should provide the informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent with sufficient time to determine which entity will provide the initial notification for contracts in effect on August 1, 2008.

Section 133.4(g): Some commenters state that insurance carriers are entitled to pay a health care provider "at a contracted fee" if the fee was negotiated by a certified workers' compensation health care network contractual agreement. Another commenter states its understanding that proposed §133.4(g) only applies to "contracted fees" that were negotiated by an informal or voluntary network. Some commenters believe this proposed subsection could mistakenly be interpreted to apply to payments made under a certified health care network. Some commenters recommend the following new language to clarify that this proposed subsection does not apply to certified networks: "The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal or voluntary network if: **…"**

Agency Response: The Division agrees that adopted §133.4 applies to informal network and voluntary network fee arrangements with a health care provider and not contracts between certified health care networks and health care providers. The Division has adopted new §133.4(a) to state that this section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider in

accordance with Labor Code §413.011 and §413.0115. The Division further agrees that it is necessary to change the language of adopted §133.4(g) to clarify that adopted §133.4 does not apply to certified health care networks as follows: "The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:.."

Sections 133.4(g) and (h): A commenter recommends that insurance carriers be required to pay fees in accordance with the Division's fee guidelines if notification to the health care provider does not meet the requirements of subsections (a)-(d). The commenter also recommends language be added to new §133.4(g) which states that a carrier is not entitled to access a contracted rate for services provided prior to, the later of, the dates disclosed in subsection (b), or the date the notice under subsection (c) is sent plus seven calendar days.

Agency Response: The Division disagrees that the recommended language is necessary. Adopted §133.4(g) clarifies the instances in which an insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network. Additionally, adopted §133.4(h) states that Division fee guidelines will apply if the provisions of §133.4(g) are not met, or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable pursuant to §134.1(e)(3), relating to Medical Reimbursement.

Section 133.4(h): A commenter states that the Division's fee guidelines do not provide a payment amount for every procedure that may be performed by a health care provider. The commenter gives the example of the fee guidelines providing for the use of unlisted procedure codes for which there is not a specific rate of reimbursement established in the fee guidelines. As such, the commenter recommends the following language for proposed subsection (h):

"(h) Application of Division Fee Guidelines. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply. In the event the Division fee guidelines do not specify a reimbursement for a procedure or the procedure is appropriately billed under an unlisted procedure code, reimbursement will be based on fair and reasonable reimbursement as defined in §134.1(d). "

Another commenter recommends adding the following sentence to proposed subsection (h) in order to give the parties guidance on the standards for reimbursement in the absence of an applicable Division fee guideline. "If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section, and as provided in Labor Code §413.011(d-1), reimbursement will be based on fair and reasonable reimbursement as defined in §134.1(d)."

Another commenter requests retention of proposed §133.4(h) for application of the fee schedule amount when the insurance carrier is not entitled to pay a health care

provider at a contracted rate as outlined in proposed subsection (g) of this section and as provided in Labor Code §413.011(d-1).

Agency Response: The Division agrees to provide a clarification. The Division has added language to adopted §133.4(h) to clarify that in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3).

Section 133.4(i): A commenter requests retaining proposed §133.4(i) to allow for the assessment of administrative penalties against informal and voluntary networks that take discounts without having complied with statutory and administrative requirements.

Agency Response: The Division appreciates the comment. New §133.4(i) clarifies that an insurance carrier may be held liable for administrative violations that result from noncompliance with Labor Code provisions and Division rules.

Section 133.4(i): A commenter states opposition to this proposed subsection by stating it is beyond the rule making authority of the Division. Some commenters state that there is no legislative authority in HB 473 or Labor Code Chapter 415 in which the Texas Legislature gave the Division expressed or implied authority to hold an insurance carrier responsible for administrative violations committed by an informal network, voluntary network, or any other legislatively recognized stakeholder. Some commenters believe the only penalty identified in HB 473 for the failure to give proper notice to the

health care provider under §413.011(d-2) is the obligation to reimburse the provider in accordance with the Division fee guidelines as stated in §413.011(d-3)(3)(B). The commenter states that imposing additional penalties against the insurance carrier would be wrong and biased against the insurance carrier, especially if the notification violation was committed by another stakeholder. Another commenter recommends changing this subsection to hold the entity responsible for delivering the notice liable for administrative violations, rather than the insurance carrier.

A commenter recommends the following new language for proposed §133.4(i): "(i) Administrative Violations. If notification to the health care provider does not meet the requirements of subsections (b)-(e) of this section, the insurance carrier may be held liable for any administrative violations if the contract between the insurance carrier and the informal or voluntary network specifies that it is the responsibility of the insurance carrier to notify health care providers in the manner required by subsections (b)-(e) of this section. In the event the contract between the insurance carrier and informal or voluntary network specifies that it is the responsibility of the informal or voluntary network to notify health care providers in the manner set forth in subsections (b)-(e) of this section, the informal or voluntary network may be held liable for any administrative violations."

A commenter states that with the passage of HB 473, the TDI now has regulatory authority over informal and voluntary networks. The commenter states that if an informal or voluntary network fails to comply with the notification requirements of this

section and is responsible for notifying health care providers under the terms of the contract that has been entered into by the informal or voluntary network and the insurance carrier, the informal or voluntary network should be held liable for any administrative violations of the rules.

A commenter notes that the Division has acknowledged in proposed §133.5(e) that the Texas Department of Insurance has regulatory authority over informal and voluntary networks that includes imposing penalties when the statute or a rule is not complied with by the informal or voluntary network. Proposed §133.5(e) provides that the Division may penalize an informal or voluntary network that fails to report data required by § 413.0115 of the Texas Labor Code and proposed §133.5.

Agency Response: The Division disagrees with the recommendation to delete language in new §133.4(i) that makes the insurance carrier potentially liable for administrative violations resulting from noncompliance with new §133.4. The Division also disagrees with the recommendation to change new §133.4(i) to clarify that the entity responsible for delivering the notice is liable for any administrative violations imposed by the Division. Although Labor Code §413.011 (d-1) and (d-2) allow the insurance carrier, the carrier's authorized agent or the informal or voluntary network to deliver the health care provider notice under this section, Labor Code §413.015 requires insurance carriers to make appropriate payment for health care in accordance with the agency's medical policies and fee guidelines and Labor Code §413.016 authorizes the

Division to investigate and take enforcement action against an insurance carrier that pays for health care inconsistent with the agency's medical policies or fee guidelines.

In accordance with Labor Code §413.011(d-1) insurance carriers are allowed to pay a fee to health care providers that is inconsistent with the agency's fee guidelines if certain requirements are met. If a carrier chooses to use an informal or voluntary network to contract with health care providers for fees that are inconsistent with the agency's fee guidelines, Labor Code §413.011(d-1)(1) and (2) state that 1) there must be a contract between the insurance carrier or its authorized agent and the informal or voluntary network that authorizes the informal or voluntary network to contract with health care providers on its behalf; and 2) the contractual arrangement between the informal or voluntary network and the health care provider include a specific fee schedule and complies with the health care provider notice requirements laid out in Labor Code §413.011 (d-2) and Division rules. The Division's interpretation of the statutory language under Labor Code §413.011, §413.015 and §413.016 is that the insurance carrier is ultimately responsible for ensuring that the proper payment is made for health care services in the Texas workers' compensation system and an informal or voluntary network is acting on behalf of the insurance carrier to obtain contractual fee arrangements with health care providers that are inconsistent with the agency's fee guidelines. HB 473 authorized the continued use of contractual fee arrangements outside of certified workers' compensation health care networks until January 1, 2011, but placed certain requirements, including the health care provider notice requirement in

place in order for those contractual fee arrangements to be valid. As such, the Division has determined that the insurance carrier cannot ensure that proper payment is made to health care providers under the Act and applicable Division rules without ensuring that all of the requirements which authorize the ability to pay a fee inconsistent with the agency's fee guidelines, namely the notice provision under Labor Code §413.011, are also met.

Additionally, Labor Code §413.0115(c) and new §133.5 specifically require the informal network or voluntary network to report certain information to the Division. New §133.5(e) acknowledges this statutory responsibility imposed on the informal or voluntary network and accordingly provides that failure to report the specified data may result in an administrative violation.

Section 133.4(i). A commenter recommends new language providing that this section subjects an entity to an administrative penalty of $10,000.

Agency Response: The Division disagrees. The Division has added language to §133.4(i) to clarify that the insurance carrier may be held liable for administrative violations in accordance with applicable Labor Code provisions and Division rules if there is non-compliance with the notice to the health care provider. Labor Code §415.021 provides that the Commissioner of Workers' Compensation may assess administrative penalties against any person who violates the Labor provisions and Division rules of up to $25,000 per day per occurrence.

Section 133.4(k): A commenter recommends changing proposed §133.4(k) to clarify the expiration date of this section and that this section will apply to unresolved fee disputes over services rendered prior to January 1, 2011:

(k) In accordance with §413.011(d-6), the provisions of this rule shall expire January 1, 2011. Notwithstanding the provisions of this subsection, the provisions of this rule apply to medical services covered by an informal or voluntary network agreement that were rendered on or before December 31, 2010.

Another commenter recommends changing this proposed subsection to state, "In accordance with §413.011(d-6), the provisions of this rule apply to medical services covered by an informal or voluntary network agreement that were rendered on or before December 31, 2010." The commenters believe the proposed wording may create confusion in 2011 as to whether or not there is any rule in place to assist in deciding unresolved fee disputes over services rendered prior to January 1, 2011.

Agency Response: The Division agrees that this section will apply to unresolved fee disputes over health care services rendered between August 1, 2008, and December 31, 2010. The Division has adopted §133.4(a) to state that "this section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider in accordance with Labor Code §413.011 and §413.0115. In addition, the Division has added language to adopted §133.4(k) to clarify that this section will

continue to apply to health care services that were rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider.

`Section 133.5(a)(5): A commenter states that the Division's on-line reporting system only allows the insurance carrier to be linked with one associated entity. The commenter states that an insurance carrier may have more than one entity working on its behalf and, therefore, recommends that the Division consider revising its on-line reporting system to accommodate multiple linked entities.

Agency Response: The Division appreciates the recommendation to revise its on-line reporting system to allow informal and voluntary networks to report multiple insurance carriers, insurance carrier agents, and other entities with whom they are associated. On March 6, 2008, the Division modified the on-line reporting system to allow informal networks and voluntary networks to report multiple relationships.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For, with changes: Concentra, Coventry, Insurance Council of Texas, Texas Mutual Insurance Company, Zenith, and Texas Medical Association

Neither For Nor Against: RGV Healthcare Systems, Southwest Medical Provider Network, and Rockport Healthcare Group,

6. STATUTORY AUTHORITY. The amendments and new sections are adopted under the Labor Code §§413.011, 413.015, 413.0115, 413.016, 408.0223 (repealed), 415.021, 415.023, 402.00111, and 402.061.

Section 413.011 requires the Commissioner by rule to establish the time and manner for an informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, to notify each health care provider of any person that is given access to the network's fee arrangements with the health care provider. Section 413.015 requires the Commissioner by rule to review and audit the payment by insurance carriers of charges for medical services provided under the subtitle to ensure compliance of health care providers and insurance carriers with the medical policies and fee guidelines adopted by the Commissioner. Section 413.0115 requires voluntary networks and informal networks to report specific information to the Division. Section 413.016(a) provides that the Division order a refund of charges paid to a health care provider in excess of those allowed by the medical policies or fee guidelines. Section 413.016(b) provides that if the Division determines that an insurance carrier has paid medical charges that are inconsistent with the medical policies or fee guidelines adopted by the Commissioner, the Division shall investigate the potential violation. Former §408.0223 established the requirements of an insurance carrier network before its repeal by Chapter 265, Acts of the 79th Legislature, Regular Session, 2005, and constitutes the manner by which a voluntary network is defined. Section 415.021 provides that the Commissioner may assess an administrative penalty against a person

who commits an administrative violation. Section 415.023 provides for certain administrative violations as a matter of practice. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides the Commissioner with the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

7. TEXT.

Subchapter A. General Rules for Medical Billing and Processing

§133.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Bill review -- Review of any aspect of a medical bill, including retrospective review, in accordance with the Labor Code, the Insurance Code, Division or Department rules, and the appropriate fee and treatment guidelines.

(2) Complete medical bill -- A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).

(3) Emergency -- Either a medical or mental health emergency as follows:

(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part;

(B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(4) Final action on a medical bill --

(A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or

(B) denying a charge on the medical bill.

(5) Health care provider agent -- A person or entity that the health care provider contracts with or utilizes for the purpose of fulfilling the health care provider's obligations for medical bill processing under the Labor Code or Division rules.

(6) Insurance carrier agent -- A person or entity that the insurance carrier contracts with or utilizes for the purpose of providing claims services, including fulfilling

the insurance carrier's obligations for medical bill processing under the Labor Code, the Insurance Code, Division or Department rules.

(7) Pharmacy processing agent -- A person or entity that contracts with a pharmacy in accordance with Labor Code §413.0111, establishing an agent or assignee relationship, to process claims and act on behalf of the pharmacy under the terms and conditions of a contract related to services being billed. Such contracts may permit the agent or assignee to submit billings, request reconsideration, receive reimbursement, and seek medical dispute resolution for the pharmacy services billed.

(8) Retrospective review -- The process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

(9) In this chapter, the following terms have the meanings assigned by Labor Code §413.0115:

(A) Voluntary networks; and

(B) Informal networks.

§133.4. Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks.

(a) Applicability. This section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or

voluntary network fee agreement with a health care provider in accordance with Labor Code §413.011 and §413.0115.

(b) Person. Under this section "person" is defined as an individual, partnership, corporation, hospital district, insurance carrier, organization, business trust, estate trust, association, limited liability company, limited liability partnership or other entity to whom an informal network or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier. This term does not include an injured employee.

(c) Required Notice. Each informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider within the time and manner provided by this section.

(d) Notice. Notice to each contracted health care provider:

(1) must include the contact information for the informal or voluntary network, including, but not limited to, the name, physical address, and a toll-free telephone number accessible to all contracted health care providers;

(2) must include the following information in the body of the notice:

(A) name, physical address, and telephone number of any person that is given access to the informal or voluntary network's fee arrangement with a health care provider; and

(B) the start date and any end date during which any person has been given access to the health care provider's contracted fee arrangement.

(3) may be provided in an electronic format provided a paper version is available upon request by the Texas Department of Insurance, Division of Workers' Compensation (Division); and

(4) may be provided through a website link only if the website:

(A) contains the information stated in paragraphs (1), (2)(A) and (2)(B) of this subsection; and

(B) is updated at least monthly with current and correct information.

(e) Documentation. The informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall document the information provided in the notice as required by subsection (d) of this section, the method of delivery, to whom the notice was delivered, and the date of delivery. For the purpose of this section, a notice is determined to be delivered in accordance with §102.4(p) of this title (relating to General Rules for Non-Commission Communications). Failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption in a Division enforcement action and in a medical fee dispute that the health care provider did not receive the notification.

(f) Time of notification. Under this section:

(1) for contracts with health care providers in effect on August 1, 2008, initial notification must be made no later than November 1, 2008, and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis; and

(2) for contracts with health care providers entered into after August 1, 2008, initial notification must be made no later than the 30th day after the effective date of the contract and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis.

(g) Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:

(1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

(2) there are no required contracts in accordance with Labor Code §413.011 (d-1) and §413.0115.

(h) Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title.

(i) Administrative Violations. If notice to the health care provider does not meet the requirements of this section, the insurance carrier may be held liable for administrative violations in accordance with Labor Code provisions and Division rules.

(j) Severability Clause. If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

(k) Expiration. In accordance with §413.011(d-6), the provisions of this rule shall expire on January 1, 2011. This section will continue to apply to health care services that were rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider.

§133.5. Informal Network and Voluntary Network Reporting Requirements to the Division.

(a) Reporting Requirement. Each informal network and voluntary network must provide the following information to the Texas Department of Insurance, Division of Workers' Compensation (Division):

(1) the informal network or voluntary network's name and federal employer identification number (FEIN);

(2) an executive contact for official correspondence for the informal network or voluntary network;

(3) a toll-free telephone number by which a health care provider may contact the informal network or voluntary network;

(4) a list of each insurance carrier with whom the informal network or voluntary network contracts, including the insurance carrier's FEIN; and

(5) a list of each entity or insurance carrier agent associated with the informal or voluntary network working on behalf of the insurance carrier, including contact information for each entity.

(b) Reporting Format. Reports, including changes, must be submitted through the Division's on-line reporting system accessible through the Division's website at www.tdi.state.tx.us.

(c) Reporting Timeframe. Each informal network and voluntary network that has a contract with an insurance carrier or an insurance carrier's authorized agent in effect on September 1, 2007, must report to the Division in accordance with this section no later than August 1, 2008. Except as otherwise provided in this subsection, informal and voluntary networks must report to the Division no later than the 30th day after the effective date of a contract signed with an insurance carrier or an insurance carrier's authorized agent.

(d) Reporting Changes. Each informal and voluntary network shall report any changes to the information provided under subsection (a) of this section to the Division not later than the 30th day after the effective date of the change in accordance with Labor Code §413.0115 and this section.

(e) Administrative Violations. If the informal and voluntary network report does not meet the requirements of Labor Code §413.0115 and this section, the informal or voluntary network may be held liable for any administrative violations.

(f) Expiration. The provisions of this rule shall expire on January 1, 2011.

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2008.

_____
Norma Garcia
General Counsel
Texas Department of Insurance
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that amendments to §133.2 concerning Definitions, new §133.4 concerning Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks, and new §133.5 concerning Informal Network and Voluntary Network Reporting Requirements to the Division are adopted.

AND IT IS SO ORDERED.

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_____
ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

_____
Norma Garcia
General Counsel

COMMISSIONER'S ORDER NO._____